Clear Form

Prescription Assistance Intake Form

Safety Net Program • Emergency Prescription Assistance
Aging, Disability, and Veterans Services Division

Multnomah County

Date | Referral Source | Name | Phone | Agency - Select | Other

Client Information

Name • Last | First | MI | Social Security #

DOB | Phone | Medicaid # | Gender ☐ Female ☐ Male ☐ Transgender

Apt Bldg Name | Address | City | State | Zip

Total number in household

☐ Single individual ☐ Couple ☐ Parent(s) with child(ren)

Please specify other household members not listed (name/DOB/relationship)

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not Reported

Race

(check all that apply) ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ Black or African American ☐ Other (specify) ☐ Not reported or Unknown

Veteran Status

Has applicant ever served in the military? ☐ YES ☐ NO

Is applicant the surviving spouse of someone who served in the military? ☐ YES ☐ NO

Is applicant in receipt of any veterans' benefits? ☐ YES ☐ NO

Monthly Income

Applicant	$
Source	
Other household member	$
Source	
Total household income	$ 0.00

Does applicant receive Supplemental Nutrition Assistance Program benefits (SNAP)? ☐ YES ☐ NO

Other resources & assets $

Combined value of any financial asset including retirement accounts, saving bonds, mutual funds, stocks, certificates of deposit and life insurance for client & spouse

Does applicant have rep payee? ☐ YES ☐ NO

Monthly Expenses

Rent or Mortgage	$
Essential utilities (gas, electric, water, etc.)	$
Telephone	$
Cable TV	$
Car payments	$
Car insurance	$
Car fuel/oil	$
Bus fare	$
Credit card payments	$
Out-of-pocket medical costs	$
Food	$
Other (specify)	$
Total monthly expenses	$ 0.00
Income minus expenses	$ 0.00

Please complete the following questions

1. What are the circumstances leading to this request? Include already explored.

2. Does the applicant have Medicare? ☐ YES ☐ NO
   If **NO**, indicate the client's expected Medicare start date and go to question 6. Medicare start date
3. Is applicant enrolled in a Part D Drug Plan? ☐ YES ☐ NO
   If **NO**, when is client eligible to enroll in a Part D Plan? Date
4. Has applicant applied for the Part D Low Income Subsidy? ☐ YES ☐ NO
5. Part D plan name | Phone
6. Name of other insurance held by applicant
   Does this insurance cover prescriptions? ☐ YES ☐ NO
7. Describe how the applicant will meet their long-term prescription medication needs
   (some steps may be required in order for applicant to receive 3 month maximum assistance – e.g. signing up for Part D Plan, comparing plans, applying for other resources):

Prescription Drug Payment Information Form

Safety Net Program • Emergency Prescription Assistance
Aging, Disability, and Veterans Services Division

Multnomah County

Today's date					
Client name		DOB		Phone	
Pharmacy Name					
Address					
Phone					
FAX					
Contact person					

					FOR SAFETY NET STAFF ONLY	
	Name of Drug	Dosage	Quantity	Cost	Formulary	Comments
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
		TOTAL COST		$ 0.00		

Pharmacy: If you have any questions, please contact the program staff at (503) 988-8245

FOR CENTRAL ADVSD USE ONLY

ADVSD Authorization

Date

Prescription Assistance Request/Release

Safety Net Program • Emergency Prescription Assistance
Aging, Disability, and Veterans Services Division

Multnomah County

I certify the foregoing statements are true and correct to the best of my knowledge. I understand that the above information may be released to agencies in the Aging, Disability & Veterans Services network, as needed, in determining eligibility and/or providing financial assistance. I also authorize Multnomah County ADVSD to speak to my payee about financial and health-related information. The information provided here is subject to verification by authorized local or federal officials.

In order to assist you with purchasing your prescription drugs, it may be necessary for Multnomah County Aging, Disability & Veteran Services to communicate with your pharmacy regarding your prescriptions, your health insurance information, and the cost of your medications. Please sign below to authorize communication between ADVSD and your pharmacy staff.

My health information:
I agree to the disclosure of health and prescription drug information (including cost and insurance coverage) to the pharmacy listed below:

Pharmacy Name	**Pharmacy Address**	**Pharmacy Phone**

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until

Month	Day	Year

☐ Until ADVSD delivers to the recipient, the information described.

☐ Until the following event occurs:

We, the undersigned, have participated in completing this application and understand that by signing, the applicant agrees to follow-through with the steps of this plan.

Applicant Signature	Date

Interviewer Signature	Date	Agency and/or Phone

Return completed form (3 pages) to

ADVSD Emergency Rx Assistance Program

EMAIL (secure) • advsd.safetynet@multco.us

US Mail • PO Box 40488, Portland, OR 97240-0488

FAX • (503) 988-6199